COVENTRY HEALTH CARE OF DELAWARE

RETRO FORM

- Please **PRINT** all requested information.
- Please complete this application **only** if you want to change your coverage, change your spouse/dependent status or if you have sent in your payment for the month and have new employees.
- If this is an addition, please include application and transmittal.
- Month of coverage it affects _____.
- Refund [ ] or Addition [ ]

NON PAYROLL GROUP NUMBER **NON PAYROLL GROUP NAME** **GROUP PHONE NUMBER**

NAME – Last, First, Middle Initial, Jr., Sr. SS# Birth Date

_____/____/_____/_____/_____

[ ] I AM APPLYING FOR A CHANGE IN MY SPOUSE/DEPENDENT STATUS

Change my coverage to:

[ ] Employee [ ] Employee & Spouse [ ] Employee & Child(ren) [ ] Family

COMMENTS: (Example you had Family coverage and child is over 21 and you switch to Employee/Spouse.)

CHECK ALL THAT APPLY	**LIST NAME AND SS# BELOW** First, Middle Initial (and Last Name, if Different) And Social Security No.	**BIRTH DATE**	**REASON**
[ ] Add [ ] Spouse [ ] Remove			[ ] Marriage [ ] Divorce [ ] Birth [ ] Other
[ ] Add [ ] Son [ ] Remove [ ] Daughter			[ ] Marriage [ ] Divorce [ ] Birth [ ] Other
[ ] Add [ ] Son [ ] Remove [ ] Daughter			[ ] Marriage [ ] Divorce [ ] Birth [ ] Other

I CERTIFY that the above representations and information supplied by me are true, complete and accurate. I understand that I am applying for renewal of an existing contract for health benefits. I agree that such coverage, regardless of the level of benefits selected is subject to all of the terms and conditions of any contract issued to me, and of any prior application filed by me. My coverage shall be void if any statement or representation made herein, or any part thereof, is false or incomplete.

Your Signature **Current Date**